		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025619

Facility Name: Shawnee Christian Nursing Ctr

Address: 1901 North 13th - P.O. Box 680 (Number) Herrin (City) 62948-0680 (Zip Code)

County: Williamson

Telephone Number: 618-942-7391 **Fax #** ( )

IDPA ID Number: 37-0841562005

Date of Initial License for Current Owners: 09/01/80

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501©3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2001 to June 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark Havrilka

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) William O. Buskirk, CPA

(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624

(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	159	Skilled (SNF)	159	58,035	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,035	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,394	7,003	3,569	32,966	8
9	SNF/PED					9
10	ICF	9,008	7,792		16,800	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,402	14,795	3,569	49,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.75%

D. How many bed-hold days during this year were paid by Public Aid?
17 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 09/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	198,619	17,305	12,036	227,960		227,960	(12)	227,948			1
2	Food Purchase		182,622		182,622		182,622	259	182,881			2
3	Housekeeping	119,047	10,712		129,759		129,759		129,759			3
4	Laundry	86,045	7,716		93,761		93,761		93,761			4
5	Heat and Other Utilities			120,570	120,570		120,570	3,582	124,152			5
6	Maintenance	38,580	26,090	15,500	80,170		80,170	6,040	86,210			6
7	Other (specify):*											7
8	**TOTAL General Services**	442,291	244,445	148,106	834,842		834,842	9,869	844,711			8
	B. Health Care and Programs											
9	Medical Director			6,500	6,500		6,500		6,500			9
10	Nursing and Medical Records	1,615,930	70,150	13,915	1,699,995		1,699,995	(2,514)	1,697,481			10
10a	Therapy			11,938	11,938		11,938		11,938			10a
11	Activities	52,939			52,939		52,939		52,939			11
12	Social Services	67,653	875	6,128	74,656		74,656		74,656			12
13	Nurse Aide Training											13
14	Program Transportation		1,232		1,232		1,232		1,232			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,736,522	72,257	38,481	1,847,260		1,847,260	(2,514)	1,844,746			16
	C. General Administration											
17	Administrative	59,820	1,703	86,616	148,139		148,139	(35,428)	112,711			17
18	Directors Fees											18
19	Professional Services			3,821	3,821		3,821	11,322	15,143			19
20	Dues, Fees, Subscriptions & Promotions			27,957	27,957		27,957	(50)	27,907			20
21	Clerical & General Office Expenses	54,151	20,337	59,824	134,312		134,312	9,176	143,488			21
22	Employee Benefits & Payroll Taxes			448,043	448,043		448,043	18,424	466,467			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,109	10,109		10,109	5,257	15,366			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,902	90,902		90,902	2,198	93,100			26
27	Other (specify):*											27
28	**TOTAL General Administration**	113,971	22,040	727,272	863,283		863,283	10,899	874,182			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,292,784	338,742	913,859	3,545,385		3,545,385	18,254	3,563,639			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shawnee Christian Nursing Ctr #0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			154,955	154,955	(4,138)	150,817	15,905	166,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			501,020	501,020		501,020	4,710	505,730			32
33	Real Estate Taxes			318	318		318		318			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Deferred Bond Costs			1,291	1,291		1,291		1,291			36
37	**TOTAL Ownership**			657,584	657,584	(4,138)	653,446	20,615	674,061			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	20,039	1,050		21,089		21,089		21,089			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,053	87,053		87,053		87,053			42
43	Other (specify):*					4,138	4,138		4,138			43
44	**TOTAL Special Cost Centers**	20,039	1,050	87,053	108,142	4,138	112,280		112,280			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,312,823	339,792	1,658,496	4,311,111		4,311,111	38,869	4,349,980			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,638	30		9
10	Interest and Other Investment Income	(5,310)	32		10
11	Discounts, Allowances, Rebates & Refunds	259	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	21		24
25	Fund Raising, Advertising and Promotional	(50)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(25,203)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,678)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	72,547		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 72,547		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 38,869		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Shawnee Christian Nursing Ctr

ID# 0025619

Report Period Beginning: July 1, 2001

Ending: June 30, 2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expense	$ (32,709)	21	1
2	Medical - Oxygen Income	(2,330)	10	2
3	Pharmacy Income - Private	(184)	10	3
4	PY Deferred Bond Cost Expense	10,020	32	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(25,203)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(12)	0	0	0	0	0	0	0	0	0	0	(12)	1
2	Food Purchase	259	0	0	0	0	0	0	0	0	0	0	259	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,582	0	0	0	0	0	0	0	0	0	3,582	5
6	Maintenance	0	6,040	0	0	0	0	0	0	0	0	0	6,040	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	247	9,622	0	0	0	0	0	0	0	0	0	9,869	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,514)	0	0	0	0	0	0	0	0	0	0	(2,514)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,514)	0	0	0	0	0	0	0	0	0	0	(2,514)	16
	C. General Administration													
17	Administrative	0	(35,428)	0	0	0	0	0	0	0	0	0	(35,428)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,322	0	0	0	0	0	0	0	0	0	11,322	19
20	Fees, Subscriptions & Promotions	(50)	0	0	0	0	0	0	0	0	0	0	(50)	20
21	Clerical & General Office Expenses	(44,709)	53,885	0	0	0	0	0	0	0	0	0	9,176	21
22	Employee Benefits & Payroll Taxes	0	18,424	0	0	0	0	0	0	0	0	0	18,424	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,257	0	0	0	0	0	0	0	0	0	5,257	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,198	0	0	0	0	0	0	0	0	0	2,198	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(44,759)	55,658	0	0	0	0	0	0	0	0	0	10,899	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,026)	65,280	0	0	0	0	0	0	0	0	0	18,254	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,638	7,267	0	0	0	0	0	0	0	0	0	15,905	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	4,710	0	0	0	0	0	0	0	0	0	0	4,710	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	13,348	7,267	0	0	0	0	0	0	0	0	0	20,615	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,678)	72,547	0	0	0	0	0	0	0	0	0	38,869	45

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc.	100.00%	$ 3,582	$ 3,582	1
2	V	6	Maintenance				6,040	6,040	2
3	V	17	Administrative	86,616			51,188	(35,428)	3
4	V	18	Directors						4
5	V	19	Professional Services				11,322	11,322	5
6	V	20	Fees Subscriptions						6
7	V	21	Clerical				53,885	53,885	7
8	V	22	Employee Benefits				18,424	18,424	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				5,257	5,257	10
11	V	26	Insurance				2,198	2,198	11
12	V	30	Depreciation				7,267	7,267	12
13	V								13
14	Total			$ 86,616			$ 159,163	$ * 72,547	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Herrin		x	Refinance Debt	$19,733.00	09/01/93	$ 2,720,000	$ 2,240,000	09/01/18	0.0700	$ 158,842	1
2	1996-A Bonds	x		Refinance Debt	$1,566.00	07/01/96	225,000	204,225	07/01/21	0.0700	14,413	2
3	1999-A Bonds	x		Refinance Debt	$7,161.00	01/01/99	1,000,000	941,800	01/01/24	0.0700	64,055	3
4	2001-Z Bonds	x		Refinance Debt	$18,666.00	10/01/01	3,200,000	3,200,000	10/01/31	0.0700	168,000	4
5	Retired Bonds	x		Refinance Debt							45,485	5
	Working Capital											
6	CHI Bond Fund	x		Refinance Debt				167,596		0.0850	19,104	6
7	CHI Revolving Fund	x		Refinance Debt				111,327			25,769	7
8	Financing Fee amort.	x		Refinance Debt							5,352	8
9	TOTAL Facility Related				$47,126.00		$ 7,145,000	$ 6,864,948			$ 501,020	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,145,000	$ 6,864,948			$ 501,020	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shawnee Christian Nursing Ctr COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0025619

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-18-429-008	007 000 230 - W1S N75 408-138	$ 295.00	$ 295.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 295.00	$ 295.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,100 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	180,000	1980	$ 71,171	1
2	Home Office Allocation			7,026	2
3	TOTALS	180,000		$ 78,197	3

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	159		1980	1971	$ 1,666,025	$ 44,338	35	$ 47,601	$ 3,263	$ 968,262	4
5			1980	1980	107,504		20	5,375	5,375		5
6											6
7											7
8	Home Office Allocation				50,240	1,472		1,472		24,713	8
	Improvement Type**										
9	Storage Building			1981	6,510		20			6,510	9
10	Roof Repair			1981	3,660		5			3,660	10
11	Hearing & A/C System			1982	37,091	1,537	20	1,537		37,091	11
12	TV System			1982	9,873		15			9,873	12
13	TV System			1982	1,182	59	20	59		1,170	13
14	Building Improvements			1982	159,808	4,098	39	4,098		84,009	14
15	Building Improvements			1983	22,362	588	38	588		11,466	15
16	Roof Repair			1983	4,538		10			4,538	16
17	Smoke Alarm			1984	650	33	20	33		610	17
18	Building Improvements			1985	44,866	1,122	40	1,122		18,794	18
19	Roof Replacement			1985	192,604	5,503	35	5,503		93,551	19
20	Windows			1985	39,252	981	40	981		16,432	20
21	Ceiling Tile			1985	4,232	212	20	212		3,516	21
22	A/C System			1985	4,200		10			4,200	22
23	Light Fixtures			1985	777		10			777	23
24	Ceiling Tile			1986	1,874	94	20	94		1,465	24
25	Duct Work			1986	1,600	80	20	80		1,260	25
26	Building Improvements			1986	4,103		10			4,103	26
27	Wiring			1987	891	45	20	45		698	27
28	Dining & Adminstration Wing			1987	688,723	17,218	40	17,218		260,936	28
29	Remodeling			1987	705	35	20	35		522	29
30	Ceiling Duct			1987	510	26	20	26		388	30
31	Duct Work			1987	635	32	20	32		472	31
32	Energy System			1987	11,000	733	15	733		10,812	32
33	Remodeling			1988	552	28	20	28		401	33
34	Electrical Supply			1988	373	19	20	19		272	34
35	Air Cleaner & Duct			1988	1,694		10			1,694	35
36	Mirror			1988	1,562		10			1,562	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HVAC System	1988	$ 4,675	$ 234	20	$ 234	$	$ 3,315	37
38	Windows	1988	705	20	35	20		282	38
39	Baseboard	1988	739	37	20	37		521	39
40	Heat Pumps	1988	27,223	1,361	20	1,361		19,167	40
41	Floor Tile	1988	340		5			340	41
42	Duct Work	1988	22,066	1,103	20	1,103		15,258	42
43	Roof Work	1988	1,254	84	15	84		1,176	43
44	Towel & Soap Dispenser	1988	1,976		10			1,976	44
45	Title Policy	1988	3,740	94	40	94		1,300	45
46	Hampton Settlement	1988	74,000	1,850	40	1,850		25,592	46
47	Wall Heat Pump	1989	1,300		10			1,300	47
48	Flourescent Light	1989	673		10			673	48
49	A/C Electrical Work	1989	6,950		8			6,950	49
50	Heat Pumps/Duct System	1989	39,940	1,997	20	1,997		25,961	50
51	Down Spouts	1989	600	40	15	40		513	51
52	Laundry Room Roof	1989	2,200	147	15	147		1,886	52
53	Energy Management System	1989	5,692	379	20	379		4,832	53
54	Heat Pumps	1989	63,466	3,173	20	3,173		39,663	54
55	Wander Guard	1989	11,417	571	20	571		7,138	55
56	Air Conditioning	1989	5,820		8			5,820	56
57	Ceiling Tile	1989	1,868		10			1,868	57
58	Trimming (1200")	1990	840		5			840	58
59	Remodel Rooms	1990	2,446	122	20	122		1,525	59
60	Baseboard (120')	1990	706		5			706	60
61	Shelving	1990	851		5			851	61
62	Floor Tile	1990	426		5			426	62
63	Water Heater	1990	386	26	15	26		321	63
64	Smoke Detectors	1990	890		5			890	64
65	Flourescent Lights (20)	1990	775		10			775	65
66	Door & Hardware	1990	541		5			541	66
67	Wallpaper	1990	919		5			919	67
68	Relocate Sprinklers	1990	583		10			583	68
69	Brick A/C Holes	1990	1,352	34	40	34		414	69
70	TOTAL (lines 4 thru 69)		$ 3,356,955	$ 89,525		$ 98,163	$ 8,638	$ 1,748,079	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,356,955	$ 89,525		$ 98,163	$ 8,638	$ 1,748,079	1
2	Door Frames	1990	303		5			303	2
3	Paint & Wallpaper	1990	1,118		5			1,118	3
4	Heating Receivers (11)	1990	1,975	132	15	132		1,595	4
5	Kickplates	1990	763		10			763	5
6	Air Conditioner	1990	1,184		8			1,184	6
7	Door Alarm	1990	423		5			423	7
8	Doors & Lock	1990	35,817	1,791	20	1,791		21,343	8
9	Lights (13)	1990	590		10			590	9
10	Door Kickplates (118)	1990	2,104		10			2,104	10
11	Electrical Connection to Emergency Generator	1990	6,930	347	20	347		4,019	11
12	Remodeling	1991	2,733	137	20	137		1,576	12
13	Door Locks	1991	510	26	20	26		299	13
14	Floor Tile Install	1991	10,926		5			10,926	14
15	Cove Base	1991	1,763		10			1,763	15
16	Handrail, Drywall	1991	569		5			569	16
17	Exit Fixtures	1991	1,619		10			1,619	17
18	A/C Units (2)	1991	15,885		10			15,885	18
19	Wallcoverings	1991	483		5			483	19
20	Heat Pump	1991	5,267	351	15	351		3,802	20
21	Walk-in Freezer	1991	8,643	576	15	576		6,240	21
22	Water Heater	1991	867	33	10	33		867	22
23	Hall Lights	1992	2,091	123	10	123		2,091	23
24	Water Heaters	1992	3,164	211	15	211		2,198	24
25	Heat Pump	1992	653	44	15	44		458	25
26	Heat Pump	1992	7,265	484	15	484		4,880	26
27	4' Loop System	1992	3,723	344	10	344		3,723	27
28	Building Lighting	1992	1,142	114	10	114		1,064	28
29	Metal Door Frames	1992	840	42	20	42		416	29
30	Garbage Disposals	1994	2,072		5			2,072	30
31	Tub Room Remodel	1993	4,015	402	10	402		3,719	31
32	Building Remodeling	1993	6,103	305	20	305		2,760	32
33	Honeywell System	1993	5,031	252	20	252		2,289	33
34	TOTAL (lines 1 thru 33)		$ 3,493,526	$ 95,239		$ 103,877	$ 8,638	$ 1,851,220	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,493,526	$ 95,239		$ 103,877	$ 8,638	$ 1,851,220	1
2	Sink & Doors	1994	3,381	338	10	338		2,732	2
3									3
4	Roof Repair	1993	4,608	307	15	307		2,661	4
5	Storage Room Remodel	1994	2,020	101	20	101		859	5
6	Sewage Pump System	1994	4,256	426	10	426		3,515	6
7	Fire/Garage Door	1994	526		5			526	7
8	Handrails	1995	6,079	608	10	608		4,354	8
9	Remodeling (Side 1)	1995	7,992		5			7,992	9
10	Cabinets	1995	2,343	156	15	156		1,099	10
11	Therapy/Bath	1996	181,372	7,557	24	7,557		46,601	11
12	Fire Alarm System Relay	1996	2,596	260	10	260		1,538	12
13	Cnvt Tub Room/Quiet	1997	1,296	174	5	174		1,296	13
14	Water Fountain	1997	502	77	5	77		502	14
15	Roof Repairs	1997	534	79	5	79		534	15
16	Compressor	1997	973		3			973	16
17	Compressor Unit 1516	1997	2,377		3			2,377	17
18	Roof Work	1997	1,276	255	5	255		1,211	18
19	Remodeling (Side 2 & 3)	1997	38,878	2,592	15	2,592		8,208	19
20	Replace/Rewire Hot Water Heater	1998	9,445	945	10	945		4,095	20
21	Kitchen Heaters	1998	793	159	3	159		662	21
22	Compressor/Library #24	1999	2,972		3			2,972	22
23	Keyless locks	1999	1,423	285	5	285		1,092	23
24	Wallpaper dining room	1999	3,071	614	5	614		1,996	24
25	120 gal water heater	1999	3,000	300	10	300		925	25
26	Mixing valve water heater	2000	961	192	5	192		560	26
27	Compressor	2000	1,133	378	3	378		1,040	27
28	Security control system	2000	940	94	10	94		251	28
29	Remodel admin office/wiring	2000	1,147	229	5	229		526	29
30	Rooftop cond unit	2000	3,373	337	10	337		730	30
31	4 ton A/C	2000	2,590	518	5	518		1,079	31
32	4 ton hest pumps	2000	4,780	478	10	478		996	32
33	4 TON HEAT PUMPS	2000	2,692	269	10	269		493	33
34	TOTAL (lines 1 thru 33)		$ 3,792,855	$ 112,967		$ 121,605	$ 8,638	$ 1,955,615	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,792,855	$ 112,967		$ 121,605	$ 8,638	$ 1,955,615	1
2	REMODEL ROOMS 18,20,22,24,37	2000	2,214	221	10	221		387	2
3	REMODEL ROOMS 9-17	2001	2,657	266	10	266		355	3
4	INSTALL GREASE TRAP	2001	886	177	5	177		221	4
5	4 Person Booth Island (Bolted to Floor)	7/1/2001	593	59	10	59		59	5
6	(3) 4 Ton Heat Pumps	8/22/2001	7,985	732	10	732		732	6
7	Door Control System	1/1/2002	12,860	643	10	643		643	7
8	Countertop-Nursing Station Side 1	1/1/2002	750	25	15	25		25	8
9	Install Evap and Condenser in Walk-In Freezer	3/6/2002	3,685	307	4	307		307	9
10	Install Dishwasher	5/24/2002	1,100	18	10	18		18	10
11	Countertop-Nursing Station Side 2	3/22/2002	760	17	15	17		17	11
12	York Olympian Heat Pump	6/21/2002	2,265	19	10	19		19	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,828,610	$ 115,451		$ 124,089	$ 8,638	$ 1,958,398	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 318,098	$ 31,572	$ 31,572	$	Various	$ 168,706	71
72	Current Year Purchases	54,475	4,158	4,158		Various	54,475	72
73	Fully Depreciated Assets	251,975				Various	251,975	73
74	Home Office Allocation	76,396	3,309	3,309			41,511	74
75	TOTALS	$ 700,944	$ 39,039	$ 39,039	$		$ 516,667	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Van	1992	$ 14,250	$	$	$	8	$ 14,250	76
77	Patient Transportation	New Motor	2000	3,323	1,108	1,108		3	2,585	77
78										78
79	Home Office Allocation			9,001	2,486	2,486			6,293	79
80	TOTALS			$ 26,574	$ 3,594	$ 3,594	$		$ 23,128	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,634,325	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,084	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 166,722	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,638	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,498,193	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 81,971	$	$	86
87	Land Improvements	137,277	4,002	106,309	87
88	Carport	1,363	136	249	88
89	OEQT	7,204		7,204	89
90					90
91	TOTALS	$ 227,815	$ 4,138	$ 113,762	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This Workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	Workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	Applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,729	$	1
2	Cash-Patient Deposits	12,914		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 36,685)	536,784		3
4	Supply Inventory (priced at FIFO)	9,204		4
5	Short-Term Investments	2,016		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Rec	1,012		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 684,659	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	81,971		13
14	Buildings, at Historical Cost	3,779,734		14
15	Leasehold Improvements, at Historical Cost	137,276		15
16	Equipment, at Historical Cost	649,315		16
17	Accumulated Depreciation (book methods)	(2,539,438)		17
18	Deferred Charges	20,986		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	174,821		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,304,665	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,989,324	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,058	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,914		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,576		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	465		32
33	Accrued Interest Payable	13,067		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Revolving Loan Fund	111,327		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 317,407	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	6,753,621		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Annuity Payable	120,646		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,874,267	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,191,674	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,202,350)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,989,324	$	48

***(See instructions.)**

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,088,714)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,088,714)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(253,616)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PY Deferred Bond Cost Expense**	(10,020)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (263,636)	17
	B. Transfers (Itemize):		
18	**Transfer In from Affiliate**	150,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 150,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,202,350)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,640,319	1
2	Discounts and Allowances for all Levels	(649,138)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,991,181	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,941	6
7	Oxygen	2,330	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 7,271	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(528)	12
13	Barber and Beauty Care	18,847	13
14	Non-Patient Meals	12	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	184	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,515	23
	D. Non-Operating Revenue		
24	Contributions	23,261	24
25	Interest and Other Investment Income***	11,832	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 35,093	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Investments/Sale of Equipment	794	28
28a	Actuarial Gain	4,641	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,435	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,057,495	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	834,842	31
32	Health Care	1,847,260	32
33	General Administration	863,283	33
	B. Capital Expense		
34	Ownership	657,584	34
	C. Ancillary Expense		
35	Special Cost Centers	21,089	35
36	Provider Participation Fee	87,053	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,311,111	40
41	**Income before Income Taxes (line 30 minus line 40)****	(253,616)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (253,616)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,753	1,957	$ 56,324	$ 28.78	1
2	Assistant Director of Nursing	1,819	1,989	46,907	23.58	2
3	Registered Nurses	9,492	10,216	199,321	19.51	3
4	Licensed Practical Nurses	25,005	26,395	354,730	13.44	4
5	Nurse Aides & Orderlies	98,716	106,427	924,572	8.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,953	3,274	34,076	10.41	8
9	Activity Director	1,670	1,746	16,940	9.70	9
10	Activity Assistants	2,665	2,840	35,999	12.68	10
11	Social Service Workers	6,864	7,187	67,653	9.41	11
12	Dietician					12
13	Food Service Supervisor	1,817	2,025	27,807	13.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,293	20,571	170,812	8.30	15
16	Dishwashers					16
17	Maintenance Workers	3,511	3,636	38,580	10.61	17
18	Housekeepers	10,886	11,669	119,047	10.20	18
19	Laundry	9,380	10,163	86,045	8.47	19
20	Administrator	1,520	1,796	59,820	33.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,545	1,708	28,754	16.83	23
24	Clerical	1,896	2,040	25,397	12.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,735	1,814	20,039	11.05	33
34	TOTAL (lines 1 - 33)	202,520	217,453	$ 2,312,823 *	$ 10.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	140	6,500	9.3	36
37	Medical Records Consultant	10	212	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	40	960	10A.3	39
40	Physical Therapy Consultant	129	8,821	10A.3	40
41	Occupational Therapy Consultant	2	131	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	27	2,025	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	106	6,128	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	454	$ 24,777		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James E Burrell	Administrator	0	$ 59,820
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,820

B. Administrative - Other

Description	Amount
Management Expense	$ 86,616
TOTAL (agree to Schedule V, line 17, col. 3)	$ 86,616
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 3,796
FR & R Consulting	Medicare Consulting	25
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,821

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,972
Unemployment Compensation Insurance	3,000
FICA Taxes	167,890
Employee Health Insurance	175,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	6,774
Employee Physicals	1,407
Home Office Allocation	18,424
TOTAL (agree to Schedule V, line 22, col.8)	$ 466,467

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,844
Health Care Worker Background Check	
(Indicate # of checks performed)	
Achieve software fees	3,136
Accu Med software fees	1,500
LSN Assn.	6,299
Other license and fees	2,128
Promotion	50
Less: Public Relations Expense	(50)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,907

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,761
Seminar Expense	2,333
Other	1,015
Home Office Allocation	5,257
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,366

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shawnee Christian Nursing Ctr # 0025619 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN ????**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **0**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,023** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **87,053**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **7,897**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Shawnee Christian Nursing Center
Summary of Payroll Expenses

kdb
10/25/02

Payroll Tax	Unemploy Contrib	Workers Comp	Health Ins	Employee Benefits	Employee Expense	Physicals	
117,821.03	2,076.00	65,028.00	108,150.00	67,089.70			
14,470.39	312.00	9,576.00	7,000.00	7,867.69			
13,511.81	168.00	5,244.00	17,850.00	8,282.28			check
2,618.78	120.00	3,900.00	8,400.00	2,085.99			551,330.03
1,461.06	60.00	1,752.00	4,200.00	1,035.19			
8,625.34	156.00	4,980.00	16,800.00	6,182.39			
7,912.82	84.00	2,616.00	8,400.00	9,847.02	6,774.09	1,407.00	
1,472.89	24.00	876.00	4,200.00	892.56			
167,894.12	3,000.00	93,972.00	175,000.00	103,282.82	6,774.09	1,407.00	551,330.03

Less: Benefits	-103,282.82
	448,047.21

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